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Threshold 3: The feasibility of the Threshold Assessment Grid (TAG) for routine assessment of the severity of mental health problems

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Summary

Background

Evidence-based practice requires the development of measures which are suitable for everyday clinical use ('feasible'). There is no consensus as to how to establish feasibility.

Method

The feasibility of a new assessment – the Threshold Assessment Grid (TAG) – for use when making referrals to mental health services was tested by training mental health teams in using the TAG and other standardised assessments, asking referrers to 10 mental health services in London also to complete a TAG, surveying TAG users, and evaluating a feedback meeting at which TAG data were presented.

Results

101 (61%) of mental health staff received training, and 445 (74%) referrers of 600 patients completed TAGs. 65 (65%) questionnaires from TAG users were completed, and 24 (80%) of people attending feedback meetings evaluated the TAG. These allowed the extent to which the TAG is brief, simple, relevant, acceptable, available and valuable to be investigated.

Conclusion

The TAG exhibited good feasibility when used by mental health staff, and moderate feasibility when used by referrers. This approach can be used to investigate the feasibility of other standardised assessments.

Introduction

Mental health services should be provided on the basis of effectiveness and cost-efficiency, rather than any other basis (such as clinical anecdote or historical precedent). This will require an increase in the use of standardised assessments in routine clinical practice (Ellwood 1988; Salvador-Carulla 1999). However, despite the active development of new assessments by researchers, there is very limited use of any standardised assessments in practice (Bilbrey and

Bilbrey 1995; Walter et al. 1996). One reason is that assessments are not sufficiently suitable for use in normal (*i.e.* non-research based) clinical services. The notion of "feasibility" has been proposed to capture this aspect of an assessment, with high feasibility present when the assessment incorporates six desirable properties of being brief, simple, relevant, acceptable, available and valuable (Slade et al. 1999 b).

One standardised assessment which is needed is a measure of the severity of mental health problems. Such a measure would contribute to the identification of those most in need of specialist mental health care by potential referrers, providing a 'currency' for referral protocols between primary and specialist mental health services. It would also help to ensure the effective targeting of specialist services toward those most in need, and would inform both caseload monitoring and (via audit) evaluation of the implementation of policy targets. However, there is a lack of consensus about a definition of severe mental illness (Schinnar et al. 1990; Slade et al. 1997), which can lead to poorly targeted specialist mental health services (Solomon et al. 1993; Audit Commission 1994). A recently developed approach to identifying the priority group for mental health services is the Threshold Assessment Grid (TAG) (Slade et al. 2000). The TAG was developed using innovative search workshop and Delphi Consultation techniques to generate an assessment explicitly intended for routine clinical use (*i.e.* with high external validity).

The purpose of this study was (i) to develop a generalisable method for evaluating the feasibility of a standardised assessment, and (ii) to illustrate this method by investigating the feasibility of the TAG in routine mental health services.

Method

The data presented here are taken from a larger study investigating the psychometric properties of the TAG. The study took place in the context of routine mental health services, and so provides information about the feasibility of the TAG.

Assessments

Referrers to mental health services completed the TAG, and mental health team staff completed the TAG (Slade et al. 2000), the Health of the Nation Outcome Scale (HoNOS) (Wing et al. 1998), the Global Assessment of Functioning (GAF) (American Psychiatric Association 1994), and the Camberwell Assessment of Need Short Appraisal Schedule (CANSAS) (Slade et al. 1999 a). All assessments are explicitly intended for clinical use. Only data from the TAG will be reported here.

TAG assesses the severity of a person's mental health problems, and comprises a 1-page assessment requiring one tick to indicate level of severity in each of 7 domains: (i) intentional self-harm; (ii) unintentional self-harm (iii) risk from others; (iv) risk to others; (v) survival needs/disabilities; (vi) psychological needs/disabilities; and (vii) social needs/disabilities. The scale is "None", "Mild", "Moderate" and "Severe" (4-point scale) for domains (ii), (iii), (vi) and (vii), with an extra "Very severe" domain for the remaining 3 domains (which may require immediate action). It is completed by making 7 ticks. A second page of the TAG gives evidence-based guidelines for each domain, and a third page gives detailed instructions and examples for use.

CANSAS is a 22-item measure of health and social needs, with a rating of 0 (no need), 1 (met need), 2 (unmet need) or 9 (not known) for each domain. CANSAS and TAG are intended for use by any health professional, without training. HoNOS is a 12-item measure of social

disability, with a 5-point scale with anchor points provided for each point. GAF is a global rating of symptomatology and functioning, rated from 1 to 99, with anchor points provided for each 10-point interval. Both HoNOS and GAF require training before use. Only information on the training for these measures will be presented.

The training was assessed using an evaluation developed for the study, comprising three questions rating the training (information about the background to the research, information about the standardised assessments, information about the research protocol) and 4 questions about the participant's level of confidence in using the TAG, GAF, CANSAS and HoNOS. All questions were rated on a 5-point Likert scale, from 1 (Poor) to 5 (excellent).

A feasibility assessment was developed for the study. A 6-point Likert scale ("1 = Strongly agree" to "6 = Strongly disagree") was used to rate agreement with the statements shown in Table 2. Questions were alternately reversed to minimise response bias. The following questions (possible answers in brackets) were then asked: the length of time to complete the TAG (tick one of 30 seconds, 1, 2, 3, 4 or 5 minutes), what problems can you see in using the TAG routinely (tick all that apply of responses shown in Table 2 and "Other (please state)"), what could be the benefits of using the TAG routinely (tick all that apply of response shown in Table 2 and), what would help you to use the TAG with people on your caseload (blank space for response) and what would be the best use of TAG (blank space for response).

Process

The study took place between June 1999 and September 2000 in 10 mental health teams in London, chosen to represent a range of locations (3 inner London, 7 outer London), deprivation (MINI scores (Glover et al. 1998) ranging from 98 to 124, indicating deprivation at or above the national average of 100) and services (8 adult, 1 adult day care, 1 elderly).

Before the study started, training was provided for all team members in the standardised assessments to be used. The training comprised one session (60-90 minutes), provided on a group or individual basis as requested. An overview of the development of the TAG was given, including why and how the psychometric properties of the TAG were being investigated. The standardised assessments (TAG, GAF, HoNOS, CANSAS) were then described, and their use illustrated by the trainer using two vignettes (available from the authors). The trainer rated vignette 1 using TAG, giving an explanation for the rating, and encouraging discussion. Participants then rated vignette 1 using GAF, and vignette 2 using HoNOS and CANSAS, followed by feedback of ratings to the group. Finally, the research protocol was described, and participants were encouraged to contact the trainer in the future with any further questions. Active discussion took place throughout the training, with participants encouraged to interrupt the trainer for clarification when required. At the end of the training, participants were asked to complete evaluation forms, using 5-point Likert scales to assess the areas shown in Table 1.

The next 60 consecutive referrals to the service were then included. Referrers were retrospectively (within 2 working days) asked to complete a TAG, and mental health team staff were asked to complete a TAG, GAF, HoNOS and CANSAS after their initial assessment. All administrative support for this process was provided by the researchers (SC and AV), who actively tried to be minimally burdensome to the clinical teams, for example by ensuring casenotes had blank copies of the relevant assessments when retrieved by clinical staff, and by showing flexibility in contacting clinical staff. Response rate was maximised by reminders for partially completed assessments. When a partly-completed assessment was received, the assessor was either sent back the assessment form by post for completion, with missing items highlighted (where it appeared they understood how to complete the

assessment), or coached with a face-to-face meeting in completing the assessment (where it appeared the problem was difficulty in understanding the assessment).

Once all 60 patients had been assessed, referrer or mental health service staff who had completed two or more TAGs were asked to complete an assessment of the feasibility of the TAG, using a 6-point Likert scale to rate agreement with the questions shown in Table 2, ticking as many predefined benefits and problems (shown in Table 3) as wanted, and giving free-text answers to the questions "What would help you use TAG with people on your caseload?" and "What would be the best use of TAG?".

An individualised report on the 60 patients was prepared, and either sent to the team leader or presented to the team, as requested. This report covered the pathways through care of the referred patients, the scores on the standardised assessments, and the association between mental health team ratings and referrer assessments. For 5 of the 10 teams, a feedback questionnaire was given out at the end of this meeting, covering the areas shown in Tables 4 (using a 6-point Likert scale to rate agreement) and 5 (ticking all that apply), and giving free-text answers to the questions "What was useful about participating in the TAG study?" and "What type of research would be helpful in your clinical practice?".

Results

Training

165 mental health service staff were offered training, of whom 101 (61%) attended. Reasons for non-attendance were not formally investigated, and the majority of non-attendances were unexplained. However, some staff reported that they did not have enough time to attend, already had experience in using the assessments, or were not interested. 95 were trained in

groups and 6 individually. 76 (75%) of those trained returned evaluation forms. The results of the evaluation of the training are shown in Table 1.

Insert Table 1 here

There was a significant difference in level of confidence in using TAG and HoNOS (7=2.6, df=75, p=0.01).

Referrals

605 patients were included in the study (range 60-62 per site). 395 referrers referred 600 patients (with 5 self-referrals or carer referrals), comprising 245 General Practitioners (61%), 82 psychiatrists (21%), 28 psychiatric nurses (7%), 22 (6%) care managers, 6 liaison mental health team staff, and 16 others. 101 mental health service staff completed initial TAGs, comprising 39 psychiatric nurses, 41 psychiatrists, 11 clinical psychologists, 7 occupational therapists, 1 care manager and 1 art therapist. The referred patients had a mean age of 37.7 years (elderly sample 78.3), 273 (45%) were male, and had a wide range of clinical diagnoses (based on referral letter), including depression (n= 244), psychosis (n= 82), anxiety (n= 37), substance misuse (n= 32), dementia (n= 30), self-harm (n= 16), physical illness (n= 15), bipolar disorder (n= 14), panic (n= 11), and post-traumatic stress disorder (n= 11). For the 160 patients whose referrers did not complete the TAG, 88 (55%) were male, and their mean age was 36.4 years for the adult group and 78.7 for the elderly group. The study design was intended to ensure that referrers, referred patients and teams were representative of routine adult and elderly mental health services.

445 (74%) referrers completed TAGs, including 9 (2%) with some missing data. 350 patients attended for a first assessment. Of these 445 referrer-completed TAGs, 60 had a total TAG score from 0-2, 131 from 3-5, 144 from 6-8, 71 from 9-11, 27 from 12-14, and 12 from 15-24. 308 (88%) fully completed TAGs were returned, including 3 (1%) with missing data. 285 (81%) CANSAS, 274 (78%) HoNOS and 283 (81%) GAF assessments were received. Of these 308 mental health staff-completed TAGs, 67 had a total TAG score from 0-2, 126 from 3-5, 65 from 6-8, 37 from 9-11, and 13 from 12-14. Partly completed assessments were sent back once, since further efforts to obtain a complete assessment were found not to increase the return rate. Although not formally monitored, this involved approximately 12 CANSAS, 13 HoNOS, 25 GAF and no TAG assessments. The GAF in particular was difficult for some respondents, with several respondents mistakenly giving a rating for each 10-point range.

Feasibility questionnaire

55 questionnaires were given to team members (range 3 to 7 per team), and 40 (range 2 to 6) were returned (73% return rate). 45 questionnaires (including 4 to non-GP referrers) were sent to referrers (range 0 to 8 per service), and 25 (56%, range 0 to 7) were returned, only 1 from a non-GP. The higher return rate for the mental health service staff may be attributable to the positive working relationship between the researchers and the clinical staff. The results are shown in Table 2.

Insert Table 2 here

The median time to complete the TAG for referrers was 4 minutes (semi-interquartile range 3-5), and for mental health staff was 3 minutes (semi-interquartile range 2-5). The ratings by referrers and staff of problems and advantages in using TAG are shown in Table 3.

Insert Table 3 here

The question "What would help you use TAG with people on your caseload?" elicited three main themes from the mental health staff: TAG as a replacement for other assessment tools, the need to ensure TAG is freely available / incorporated into existing assessment protocols, and the use of TAG as an agreed assessment tool between teams and between disciplines. One person added that TAG would be useful "If GPs could be encouraged to fill in TAG as part of their referral process". The two negative comments were "TAG is not detailed enough the replace other assessments" and "The objectives should be clearer". The main theme arising from GPs comments was relevance to actual practice, and that if freely available then TAG appeared to be easy to use and could be useful as a predictor of mental health problems.

Mental health staff identified three main uses of TAG: part of an initial assessment package; a method for monitoring caseloads; and a way of screening referrals from primary care. Referrer comments were more idiosyncratic, although again the main theme was using TAG, "as an initial assessment for referral". One GP commented that that TAG would have been easier to complete at the time of referral rather than retrospectively (as occurred in the study).

Use of feedback report

Once the 60 patients were assessed, feedback was offered to all 10 teams, and a feedback meeting was held for 5 teams. 24 (80%) of the 30 staff attending these meetings completed a feedback questionnaire, with results shown in Tables 4 and 5.

Insert Table 4 here

Insert Table 5 here

Staff identified in free-text questions the useful aspects of being involved in the TAG study as receiving feedback (n=6), increased familiarity with standardised assessments (n=5), assessing risk, assessing severity, asking important questions, considering eligibility criteria, primary care involvement, and early involvement with the researcher. They were also asked what type of research project would be helpful in their clinical practice, and identified themes of ethnicity (twice), caseload weighting, treatment effectiveness, outcome measurement, level of suffering (not diagnosis), primary/secondary care interface, dual diagnosis, relapse prevention, cognitive-behavioural therapy for psychosis, the therapeutic impact of day care services, and what service users want from services – particularly people who find it hard to engage with current services. For one team practice change resulted from the feedback, with the development of a new opt-in approach to reducing non-attendance rates.

A telephone survey conducted in May 2001 (18 months after the first site finished and 8 months after the last site finished) found that 6 of the 10 sites were continuing to use the TAG in some form. Four sites were not using TAG, one site was using TAG with some referrals, one site was using it to survey 350 enhanced Care Programme Approach patients, and four sites were introducing the TAG for all referrals from 2001. This provides some evidence for sustainability.

Discussion

This study has assessed the implementation of a new standardised assessment – the Threshold Assessment Grid. A generalisable method for evaluating the feasibility of a standardised assessment was used, which particularly focussed on change points – the beginning and end of the study period. To identify the value of such an approach, the feasibility of the TAG in routine mental health services will now be considered with reference to the six feasibility

criteria of being brief, simple, relevant, acceptable, available and valuable (Slade et al. 1999 b).

Brief

For referrers, the TAG took on average 4 minutes to complete, and 3 minutes for mental health staff, as assessed by staff who completed two or more TAGs. There was a significant difference (Table 2, 3.3 vs 4.7, $t=4.0$, $df=62$, $p<.001$) between referrer and mental health staff agreement with the statement that TAG takes too long to complete, and 12 referrers (48%) identified administration time as a problem with the TAG, compared with 4 (10%) of mental health staff (Table 3). Overall, mental health staff are more satisfied with administration time than referrers. This may reflect a culture difference, where GPs use more forms than mental health staff, so have correspondingly lower thresholds for what they consider to be brief. Although some GP-based standardised assessments are in use, such as the 4-item CAGE alcohol questionnaire to identify alcohol problems (Mayfield et al. 1974), the use of standardised ratings for mental health is not common in most primary care services. By contrast, 95% of mental health services in the UK are now (for example) using a tiered form of the Care Programme Approach (Schneider et al. 1999). The two groups (referrers and mental health staff) may therefore have different norms for what is considered sufficiently brief.

The effect of practice on reducing administration time was not measured. Of those referrers who completed two or more TAGs, the median number completed was 2 (semi-interquartile range 2-3), whereas for mental health staff (including extra TAGs which they were asked to complete for reliability purposes, and which are not reported here) the median was 4 (semi-interquartile range 2-7). It may therefore be that practice effects accounted for the reduced administration time for mental health staff, highlighting the need to maintain behaviour

change as well as reinforcing the new behaviour of completing the TAG (Green and Eriksen 1988).

Simple

Was the TAG simple to use? This can be considered by comparison with other standardised assessments. After training, the level of confidence in using the TAG was significantly higher than in using HoNOS, and higher, though not significantly, than CANSAS or GAF (Table 1). The TAG had a higher response rate (88%) than either CANSAS (81%), GAF (81%) or HoNOS (78%). Another approach to assessing simplicity is to consider the responses from those who used the TAG, shown in Table 2. Referrers (predominantly General Practitioners) rated the TAG as more difficult to use than mental health staff, perhaps due to a combination of a general lowering in all ratings on this questionnaire and being less familiar with the terminology in the TAG (which was developed to minimise jargon, but still refers to some specific mental health concepts such as paranoia and agitated behaviour). The confidence in using standardised assessments grew significantly (Table 4, 3.5 vs 5.4, $t=3.4$, $df=21$, $p=0.003$) during the study, indicating that there may be a practice effect in assessing how simple the TAG is. These findings highlight that feasibility characteristics such as simplicity are in part a function of the person completing the assessment.

Relevant

Is the TAG relevant to the work of mental health services? In other words, does it have face validity? There was general agreement from both referrers and mental health staff (Table 2) who used the TAG that they understood what the TAG was assessing, although slightly more than a third of each group were not sure when and why a CMHT would use the TAG (Table 3). The extent to which the TAG had face validity is also demonstrated in the higher level of confidence for the TAG than the other standardised assessments after training (Table 1).

Acceptable and available

The response rate of 88% indicates that the TAG was an acceptable assessment. Although not formally monitored, substantial efforts were made by the research team to maximise the availability of forms for clinical staff – relevant forms were placed in casenotes, and duplicates were supplied when requested. This was noted by clinical staff as a motivating factor for completing the assessments.

Valuable

The most important question about the TAG is whether it is fit for its intended purpose as a referral tool. Both mental health staff and referrers indicated marginal agreement that it is useful for assessing severity (Table 2). However, 28 mental health staff (70%) thought it could be easily incorporated into the team's assessment protocol (Table 3), indicating that severity may not be the implicit measure used by CMHTs in deciding how to respond to referrals. Similarly, there was overall agreement at the feedback meeting (Table 4) that the team received information which could inform clinical practice. However, 6 of the 10 sites were still using TAG in locally-adapted ways when followed-up, which may be the best evidence that the TAG was providing valuable information.

Some methodological limitations to the study can be identified. No data on reasons for non-completion were collected from the 25 (25%) staff who received training but did not complete the training evaluation. Similarly, the 15 (27%) mental health staff and 20 (44%) referrers who did not complete the feasibility questionnaire were not characterised, reducing confidence in the generalisability of the findings. Finally, no record was kept of the number of prompts required for referrers. A conceptual

limitation of the study relates to the difficulty in assessing feasibility, which is neither a static property of the assessment nor amenable to easy investigation using a single measure – the definition of feasibility underpinning the six feasibility criteria is that "*The feasibility of an assessment indicates the extent to which it is suitable for use on a routine, sustainable and meaningful basis in typical clinical settings, when used in a specified manner and for a specified purpose*" (Slade et al. 1999 b, p.245). The resulting data on feasibility are necessarily piece-meal in nature, reflecting the nature of feasibility, which arises through an interaction of the assessment itself and the nature and purpose of its use. The study would be strengthened by identifying aspects associated with longer-term ("sustainable") use of the TAG.

In this study the researchers provided the data management, analysis and feedback. It could therefore be argued that this study was not investigating routine clinical use. However, no standardised assessment is likely to be widely used without the provision of a training and information infrastructure. What this study indicates is the need for the commitment of resources beyond purely requesting or requiring that the assessment be completed. These resources would need to be provided by a mental health service wishing to implement the use of the TAG. Future work might therefore investigate the financial cost of using the TAG, by considering the infrastructure support costs plus the clinician's time, which would allow the cost to a mental health service wishing to use TAG routinely to be identified. Similarly, the study would benefit from being replicated by researchers who were not involved in the development of the TAG, to avoid implicit researcher bias in the way feasibility is investigated.

The extent to which using TAG impacts on practice is a function of the use to which it is put and the infrastructure resourcing provided to support its implementation. One

model would be to commission services on the basis of outcomes, not activity-based data. Services would be provided for those with a specified level of mental health problem severity (*e.g.* measured using the TAG), which would provide clarity for primary care referrers about which patients are suitable for referral and would ensure that mental health services do not drift towards a focus on people with less severe problems. The work of mental health services would then need to be supported by new Outcomes Departments, to provide the infrastructure to support the routine collection and feedback of clinically-useful data. This model would both encourage reflective clinical practice with individual patients and inform local service planning and resource allocation decisions.

A method for evaluating the feasibility of a standardised assessment has been described, and illustrated with reference to using the TAG when referring to mental health services. Overall, the TAG exhibited good feasibility when used by mental health staff, and moderate feasibility when used by referrers. The main characteristic of the assessment which was identified as reducing its feasibility by referrers was administration time, which is likely to improve with practice. The method used in this study will help to get research into practice, by providing an approach to investigating whether an outcome measure is clinically useable. The feasibility of an outcome measure should be systematically investigated before it can be recommended for routine clinical use.

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Table 1: Evaluation of training (n=77)

Domain	Rating (1=Poor to 5=Excellent) Mean (range)
Information on…	
Background to study	4.2 (3-5)
Use of standardised assessments	4.1 (2-5)
Research protocol	4.0 (3-5)
Level of confidence in using…	
TAG	4.1 (3-5)
GAF	3.8 (2-5)
HoNOS	3.7 (2-5)
CANSAS	3.9 (2-5)

Table 2: Ratings of TAG feasibility

Statement	Mean agreement (s.d.)	
	Referrers (n=25)	Mental health staff (n=40)
The language used in the TAG was difficult to understand	4.6 (1.2)	5.1 (0.9)
The TAG takes too long to complete	3.3 (1.7)	4.7 (1.2)
The TAG rating instructions were easy to understand	3.0 (1.4)	2.3 (0.8)
The guidelines and further instructions were difficult to understand	4.0 (1.4)	4.7 (1.0)
I understood what the TAG was assessing	3.0 (1.4)	2.4 (1.1)
I liked the overall graphic design of the TAG	3.6 (1.1)	2.6 (1.1)
It was difficult to rate people using the TAG	3.4 (1.4)	4.4 (1.3)
The TAG is useful for assessing the severity of a person's mental health problems	3.8 (1.7)	3.1 (1.1)

(Rated on Likert scale from 1=strongly agree to 6 = strongly disagree)

Table 3: Problems and benefits in using TAG

	N (%)	
Problems	Referrer (n=25)	Mental health staff (n=40)
TAG is not freely available	3 (12)	14 (35)
Not sure when and why CMHT would use TAG	9 (36)	15 (38)
Cannot see what effect TAG would have on CMHT work	6 (24)	13 (33)
TAG duplicates other assessments already in use	4 (16)	9 (23)
Takes too much time to complete	12 (48)	4 (10)
Difficult to complete	10 (40)	2 (5)
Benefits		
TAG can be easily incorporated into the assessment protocol of the CMHT	6 (24)	28 (70)
TAG is easy to complete	2 (8)	27 (68)

Completing TAG takes up very little time	3 (12)	26 (65)
TAG is easy to understand	7 (28)	22 (55)
TAG is useful in assessing the severity of a person's mental health problems	5 (20)	18 (45)
TAG does not duplicate other assessments the CMHT is using	3 (12)	10 (25)

Table 4: Evaluation of the feedback meeting (n= 24)

Statement	Agreement
	mean (sd)
I understood the purpose of the feedback meeting	5.4 (.9)
I understood the content of the feedback meeting	5.1 (.8)
The feedback meeting was useful in that the team received information about the TAG study which could help clinical practice	4.9 (1.0)
My confidence in using standardised assessments was low before the TAG study commenced	3.5 (1.4)
My confidence in using standardised assessments was low after the TAG study had finished	5.4 (1.4)
The TAG study has now been completed in our team	5.5 (0.9)
I would happily participate in other research projects as a result of my overall participation in the TAG study	5.1 (0.9)

(Original Likert scale from 1=strongly agree to 6 = strongly disagree. All scores reversed so high score indicates agreement)

Table 5: Problems and benefits of participating in the TAG study (n=24)

Problems	n (%)
Took too much time up to participate	2 (8)
Didn't understand what the research was about	1 (4)
Not interested in research	1 (4)
Research did not seem to benefit team practice	3 (12)
No feedback to team about research	0 (0)
Benefits	
Understanding of research process	17 (71)
Confidence in using standardised assessments	17 (71)
Research was useful to team practice	16 (67)
Team cohesion	8 (33)
Feedback to team about study	18 (75)